



**SYNAGIS ORDER FORM**

TELEPHONE 1-866-525-5827

FAX 1-888-491-9742

**1. PATIENT INFORMATION** *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code) *		Night Telephone # (+Area Code)*		Mobile Telephone # (+Area Code)*
Date of Birth (MM/DD/YYYY)			Gender (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

**INSURANCE/MEDICAID INFORMATION**

Primary/Medical Insurance/Medicaid		Secondary/Pharmacy Insurance	
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)	
Group/Policy #*		Group/Policy #*	
Insurance Telephone # (+Area Code)*		Insurance Telephone # (+Area Code)*	
Employer*		Medicaid #	

**ALTERNATE SHIPPING ADDRESS\***

Last Name		First Name		M.I.
Street Address		City	State	ZIP

**2. PHYSICIAN INFORMATION** *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name	
Hospital/Clinic		Office Contact	
Street Address			
City		State	ZIP
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address
Prescriber's License #		DEA #	
UPIN#		Medicaid License #	
Primary Care Physician Name		Phone #	

\*Not required and/or Necessary for Medicaid Fee For Service

**STATEMENT OF MEDICAL NECESSITY**

**PRIMARY DIAGNOSIS:**

Gestational Age \_\_\_\_\_ Weeks \_\_\_\_\_ Days Birth Weight \_\_\_\_\_ g/kg/lbs  
Current Weight \_\_\_\_\_ kg/lbs Date Recorded / /

**Please Document All Diagnoses to the Highest Degree of ICD-9 Detail**

- ☐ Congenital Heart Disease (Please Specify) \_\_\_\_\_  
☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) \_\_\_\_\_  
☐ ≤ 24 Weeks of Gestation (765.21 – 765.22) \_\_\_\_\_  
☐ 25-26 Weeks of Gestation (765.23) \_\_\_\_\_  
☐ 27-28 Weeks of Gestation (765.24) \_\_\_\_\_  
☐ 29-30 Weeks of Gestation (765.25) \_\_\_\_\_  
☐ 31-32 Weeks of Gestation (765.26) \_\_\_\_\_  
☐ 33-34 Weeks of Gestation (765.27) \_\_\_\_\_  
☐ 35-36 Weeks of Gestation (765.28) \_\_\_\_\_  
☐ Congenital Abnormality of Respiratory System (748.3 – 748.4) \_\_\_\_\_  
☐ Immune Deficiency (042.0 or 279.2) \_\_\_\_\_  
☐ Stem Cell Transplant (041.00 – 041.09) \_\_\_\_\_  
☐ Other/Secondary Diagnosis (If Applicable) \_\_\_\_\_  
☐ Secondary Diagnosis (If Applicable) \_\_\_\_\_

**MEDICAL CRITERIA:**

**1. Chronic Lung Pulmonary Disease (CLD/BPD) and Less Than 24 Months at Start of RSV Season?**

☐ Yes ☐ No ICD-9 \_\_\_\_\_

Is Patient Receiving Medical Treatment Of CLD (Check All That Apply and Provide Last Date Received)?

☐ Oxygen: / / ☐ Corticosteroid: / /  
☐ Bronchodilator: / / ☐ Diuretic: / /

**2. Hemodynamically Significant Congenital Heart Disease and Less Than 24 Months at Start of RSV Season?**

☐ Yes ☐ No ICD-9 \_\_\_\_\_

Patient Has the Following Conditions:

☐ Moderate-Severe Pulmonary Hypertension ☐ Cyanotic Heart Disease  
☐ Acanotic Heart Disease ☐ Medications for CHF \_\_\_\_\_

Last Date Received / /

Prior Operations ☐ Yes ☐ No Describe: \_\_\_\_\_

**3. Prematurity**

- ☐ Gestational Age of < 28 Weeks, 6 Days and Less Than 12 Months at Start of RSV Season  
☐ Gestational Age of 29 Weeks, 0 Days – 31 Weeks, 6 Days and Less Than 6 Months at Start of RSV Season  
☐ Gestational Age of 32 Weeks, 0 Days – 34 Weeks, 6 Days AND  
☐ Less Than 3 Months at the Start of Synagis Season  
☐ Has At Least One Risk Factor (see below) ☐ Has NO Risk Factors

Risk Factors (Check All That Apply)

- ☐ Child Care Attendance ☐ Sibling <5 years of age  
☐ Congenital Abnormalities of Airway \_\_\_\_\_  
☐ Severe Neuromuscular Disease \_\_\_\_\_

**OTHER MEDICAL HISTORY:**

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**NICU HISTORY:** ☐ No ☐ Yes NICU Name \_\_\_\_\_

**If Yes, Please Attach the NICU Discharge Summary**

Was There a NICU Dose Administered?

☐ No ☐ Yes Dates / /

Did the Neonatologist Recommend Synagis Prior to Discharge?

☐ No ☐ Yes

Expected Date of First/Next Injection / /

Previous Injections? ☐ No ☐ Yes Dates / /

Deliver Product to ☐ Office ☐ Home

Agency Nurse to Visit Home for Injection?

☐ No ☐ Yes

**Rx**

☐ Synagis® (palivizumab) 50 and/or 100 mg Vials

☐ NKDA

Sig: Inject 15 mg/kg IM One Time Every 28 – 32 days

Dispense Quantity: QS ☐ Refill \_\_\_\_\_ Months

☐ Other: \_\_\_\_\_

☐ Dispense As Written

☐ Substitution Allowed

**Prescriber's Signature**

**Date**

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**3. FAX COMPLETED FORM TOLL-FREE TO SXC @ 1-888-491-9742**